

aspect of the bowel (Fig. 2, B), just above the internal sphincter, and it has been found in every case that the ureter could be brought to this position without the least trouble.

Having thus determined upon and exposed the seat of implantation, a pair of forceps is passed into the rectum, and pressed against the selected spot. A slight cut is now made from the external wound upon the end of the forceps; this is forced through, and the little wound dilated very accurately, so that it will receive snugly and yet without compression the ureter with its contained catheter. The forceps is then passed through and made to seize the end of the catheter, and this is drawn through the rectal wound and out of the anus. The forceps is then passed back beside the catheter through the same opening and made to grasp lightly the distal end of the ureter, or rather its rosette of bladder tissue, and this is now carefully conducted through the opening and made to protrude into the rectum. Very great care should be taken not to injure the ureter during this operation.

The same tactics are repeated upon the opposite side, and thus the ureters are drawn through so that their distal ends together with the rosette of bladder tissue, are made to project into the rectum as two prominent papillæ (Fig. 2, B). The catheters, of course, pass out through the anus, and are directed into the mouths of separate bottles containing a solution of carbolic or boracic acid. In this way one can ascertain that both kidneys are working, and if one catheter should become plugged (as happened in one of my cases) with urates or phosphates, it may be immediately withdrawn.

It will be observed that no effort is made to stitch the ureters into position. In fact, I have not found this at all necessary in any case. There is nothing to cause them to move out of their position, and the vitality of the ureters is not impaired by the traumatism which would result from such suturing. In order, however, to support the delicate ureters in their new position, and to prevent the injurious effects of any extravasation that may occur from the rectum to the wound in the pelvic cellular tissue, the wounds are packed on each side fairly firmly with iodoform gauze. This is left in position for two or three days, and when removed it is found that the parts fall together without, as a rule, allowing any extravasation from the rectum; or if there should be any, as happened in my third case, the gauze affords sufficient drainage, and the wound heals quickly by granulation.

The treatment of the exstrophied bladder tissue will depend upon the amount of bladder tissue exposed, and upon the extent of the hiatus in the abdominal wall. In my first and third and fourth cases, I found that all that was necessary was to dissect away the exposed mucous membrane of the bladder, which in these